Centers for Medicare & Medicaid Services
Special Open Door Forum:
2009 Physician Quality Reporting Initiative
With the American College of Cardiology

Wednesday, March 18, 2009
3:30pm-5pm ET
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will co-host a Special Open Door Forum on the 2009 Physician Quality Reporting Initiative (PQRI) Program with the American College of Cardiology (ACC).

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made the PQRI program permanent, but only authorized incentive payments through 2010. Eligible professionals who meet the criteria for satisfactory submission of quality measures data for services furnished during the reporting period, January 1, 2009 - December 31, 2009, will earn an incentive payment of 2.0 percent of their total allowed charges for Physician Fee Schedule (PFS) covered professional services furnished during that same period. The 2009 PQRI consists of 153 quality measures and 7 measures groups.

This Special ODF will be geared towards cardiology-specific topics related to participation in PQRI. Following the presentation, the lines will be opened to allow participants to ask questions of the ACC presenters as well as CMS PQRI subject matter expert, Sylvia Publ.

PQRI information and educational products are available on the PQRI dedicated web page located at, http://www.cms.hhs.gov/PQRI , on the CMS website.

We look forward to your participation.

Special Open Door Forum Participation Instructions:

Dial: 1-800-837-1935 Conference ID 89036042

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For TTY services dial 7-1-1 or 1-800-855-2880 and for Internet Relay services click here http://www.consumer.att.com/relay/which/index.html

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An audio recording and transcript of this Special Forum will be posted to the Special Open Door Forum website at http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning March 26, 2009.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at http://www.cms.hhs.gov/opendoorforums/

Thank you for your interest in CMS Open Door Forums.

Audio file for this transcript:

http://streaming.cms.hhs.gov/audio/SpecODF_PQRI_ACC.mp3

CENTERS FOR MEDICARE AND MEDICAID SERVICES
Special Open Door Forum: 2009 Physicians Quality Reporting Initiative with the American College of Cardiology
Moderator: Natalie Highsmith
March 18, 2009
3:30 pm ET

Operator: Good afternoon. My name is (Laurie) and I will be your conference facilitator today.

At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum, 2009 Physician Quality Reporting Initiative with the American College of Cardiology.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question, press the pound key.

At this time, it is my pleasure to turn the conference over to Natalie Highsmith. Please go ahead.

Natalie Highsmith: Thank you, (Laurie), and good day to everyone and thank you for joining us for this Special Open Door Forum on the 2009 Physician Quality Reporting Initiative program with the American College of Cardiology.

This Special Open Door Forum is geared towards cardiology-specific topics related to participation in PQRI.

For more information and educational products, there are available on the PQRI web site at www.cms.hhs.gov/pqri. Also slides for the presentation for today have been - a link has been posted for them on the Physicians Open Door Forum web page.

And you can reach that page by going to www.cms.hhs.gov/opendoorforums with an S and scroll down. On the left-hand side, you will see a link for Physicians Open Door Forums. And the link for the slides are at the bottom of the web page in the Related Links Outside CMS.

An audio recording and transcript for this call will be on the Special Open Door Forum web page and it will be available for downloading beginning March 26.

I will now turn the call over to Brian Whitman, who is the Associate for Regulatory Affairs at the American College of Cardiology.

Brian?

Brian Whitman: Thank you, Natalie. I want to repeat the thank you on behalf of the American College of Cardiology. We're very happy to be working with CMS on this call on the Physician Quality Reporting Initiative and the measures that can be reported by cardiologists.

Today's call will focus on the measures that can be reported by cardiologists through the PQRI program.

We have two goals for today's session. First, we would like cardiology practices to know enough to make an informed decision about participating in PQRI for 2009 and the future. Second, we would like to ensure that those who do make the decision to participate are in a position to participate successfully and to receive the bonus incentive payment.

You just heard the instructions about finding the slides. It may be a little bit easier if you just want to go through the ACC web page. If you go to www.acc.org, there's a link on the home page to today's PQRI call and you'll be able to find the slides very easily there.

We are fortunate to have three expert speakers on this call. First we'll have Dr. John Schaeffer, who is the President and Founder of North Ohio Heart Center. He'll explain some of the basics of the PQRI program, the cardiovascular measures, and his practice's experience with the program.

Then we'll hear from Dr. Frank Mikell, President of Prairie Cardiovascular Consultants in Illinois. He'll tell us how his practice was able to participate successfully in PQRI in 2007.

Then we'll hear from Sylvia Publ from CMS. Ms. Publ is the Senior Quality Advisor to the CMS Consortium for Quality Improvement and Survey and Certification Operations in the Office of Clinical Standards and Quality. She is an expert in quality in PQRI. She'll explain some of the issues that cardiologists encountered with the program in the past and how they might be able to avoid those problems in the future.

After those presentations, as you heard, we'll have an open question and answer session and we certainly look forward to your questions and hope to be able to provide some answers.

At this point, I'd like to turn the call over to Dr. Schaeffer.

John Schaeffer: Okay. Thanks Brian.

Just a few comments before I start -- I've been involved with the ACC and the PQRI project since the early part of 2007, shortly after the TRHCA law was put into effect. And I'm sure Sylvia Publ's going to talk more about that specifically.

The - at the time, I was the Chair of the Advocacy Committee and was on the Pay-for-Performance Committee. And the ACC realized how important it was to work very closely with CMS to make this project work.

Obviously pay-for-performance is here to stay. PQRI is the beginning steps. You've got to learn how to gather the data, capture the data, and report the data.

So we've been very involved at the ACC putting together a team of people who have been able demonstrate on an educational basis ways to be better informed about PQRI and how to make the right decision and how to gather the data.

So with that kind of preliminary comment, I'm going to start on Slide 2, which should say at the top overview of today's meeting. So what is PQRI and why is it important for cardiology?

Well, obviously Physician's Quality Reporting Initiative is a very important project to cardiology. What ambulatory measures will cardiology use? We're going to go over those.

How are those measures reported via the claims-based submission process? And we're going to spend some time talking about claims versus clinical data, how can PQRI be successfully implemented in practice.

Next slide.

What is PQRI? Well, it was the legislative mandate that was created back in December of '06 by the TRHCA law. And I'm going to - as I said, I'll let Sylvia Publ talk about that in a few minutes.

It established the physician quality reporting system and a payment incentive for voluntary participation.

Why is it important to cardiology? Because it's a starting point for testing the feasibility of claims-based and registry-based quality reporting on a self-reporting basis.

Obviously a problem with claims data is frequently it doesn't have enough clinical information to decide is quality being reported, is quality being achieved, so we had to add data to the claims data, the claims-based, in order to achieve this.

So quality measurement obviously is fundamental to quality improvement and we've got to be able to measure it.

The next slide, what measures should cardiology use? These are the measures that were developed by the ACC/AHA task force on performance measures. It was done in collaboration with the PCPI, the Physician Consortium for Performance Improvement, and endorsed by the National Quality Forum. So obviously there is a lot of effort, science, evidence, and consensus opinion regarding these performance measures.

The next slide lists the performance measures that are going to be claims-based. You see them, 5, 6, and 8. Five is ACE or ARB therapy in heart failure patients with LV systolic dysfunction. Six is anti-platelet therapy prescribed for CAD patients, so aspirin and Plavix, and 8 is beta-blocker therapy for heart failure patients with, again, LV systolic dysfunction.

You'll notice that 7 is gone. If you did 2007 and you did 2008, the earlier ones, 7 has been removed because it turned out to be very, very difficult. It had one of the highest failure rates in the range of 85% of the time we were not reporting that correctly and probably because it required two ICD-9 codes.

You not only had to give a CAD category, but you also had to have a post-MI, either recent or old. So there - CMS has decided to remove this from the claims-based. It does still exist in the registry.

The next slide is Measure 118, which is ACE or ARB therapy prescribed in CAD patients with diabetes or LV systolic dysfunction. And the last one is 152, which is a lipid panel for CAD patients.

The next slide, which is number 8 in case we've missed you, is the registry-based submission. We are qualified as a registry for the IC3. We are continuing to put that into place.

CMS will notify us specifically and others regarding registry options later in the year and the web site for connections there. We would encourage you to take a look at the IC3 option for reporting for CAD management.

How are the measures reported via a claims-based submission? Well, in order to make more robust the claims data, we had to add clinical information, so CPT II category codes were created by the AMA called QDC, quality data codes.

And these in conjunction with CMS's G codes, G codes are frequently used when a CPT II code did not specifically exist or may have caused some confusion and a G code was chosen by CMS.

So these codes, the CPT Category II codes and the G codes, which supplied a measured numerator, must be reported on the same claim as the reimbursement, which is the ICD-9 and the E&M codes.

They are the denominator. So you've got the denominator codes, ICD-9 and E&M codes, and the number codes, which reflect the quality of care that you're reporting on.

The next slide, how is reporting success determined? Eligible professionals, which are listed, have to report on at least three quality measures. There are exceptions. CMS can either - will deal with those exceptions.

For each of the three measures, reporting must occur at least 80% of the cases for the measure that is reported. Each of the cardiology measures is to be reported a minimum of once. If you looked at those measures which required once, each of your practices are going to have to decide whether you report it more than once.

Our practice actually chose to report it each time, even though the patient may be seen two or three times in the course of the year because we felt it was an ongoing learning experience for all of the physicians and staff, so the more reporting, the better they got at it.

The next slide, which lists the measures for CAD -- 6, 118, and 152 -- lists the ICD-9 denominator codes. And you can see them listed there, acute MI, the 410 family, other ischemic heart disease, the 411 family of codes, an old MI, older than eight weeks, 412, angina family, 413, CAD family 414, and, of course, if you had a bypass or PCI, you obviously have coronary disease and that would also include you in the denominator capture.

Measure 6, CAD on anti-platelet therapy, let's go over those CPT codes, which are also part of the denominator. You'll see a family code there, the 99210 to 205, those are the NPT codes. The 212 to 215 are the subsequent care in an outpatient setting and the 241 to 245 are the consults, outpatient consults.

Also included are the hospital discharge diagnoses, the 99238 and 39. And remember, those are time-based codes.

Inpatient consults are not part of the denominator capture. If you look at CMS's web site, you'll see a number of other CPT codes, but most

of those would not be used by cardiology practices in general and so we did not include those in the slides today.

The next slide, if you're going to report on measure 6, CAD with anti-platelet therapy, we need a QDC numerator code. And that one for that measure 6 is 4011F, which is that anti-platelet therapy was prescribed.

For instance, aspirin was given, clopidogrel was given. If no anti-platelet therapy was prescribed, an exception needs to be documented and the appropriate QDC code is as listed -- 4011F 1P, meaning that the physician chose not to prescribe, patient has an active peptic ulcer disease and is bleeding and it's not safe for anti-platelet therapy; 2P means the patient chose not to take the therapy, which is usually a compliance reason frequently related to cost, so for instance they couldn't afford to take the clopidogrel, so the patient did not take it; 3P tends to be a system reason. An example of that might be the insurance coverage for the medication prescribed.

The next slide is the measure 152. It's the CAD with lipid panel. You know, once again, the similar family of outpatient ambulatory CPT codes. And notice that the hospital discharge codes are not included for this measure.

The next slide, which is measure 152 talking about the CAD with lipid panel, the QDC codes are 3011F, which means that the lipid panel results are documented in the chart and they were reviewed; 8P means they are not documented and reviewed. There are no other allowable exclusions for this particular measure.

The next slide lists the components of the lipid panel, total cholesterol, HDLC, triglycerides, calculated LDLC, and, of course, if the

triglycerides are particularly high, the accurate calculation of LDL is not present, but that does not preclude the use of this QDC code. We will allow that, recognizing that the LDL calculated is not accurate and would have to be measured, but it's not required for this particular QDC code.

So the next slide goes on to the next measure, which is 118. And these are patients who have coronary disease with diabetes or LV systolic dysfunction on ACE and ARB.

And this measure has two reporting options. And we're going to cover both of those. You report the option that's applicable to the patient. If the patient has both LV, DS, and diabetes, you can report quality data for either option. It'll count as the appropriate reporting for that patient.

The next slide is option 1, let's go back and review that now. So the CPT denominator codes are the family of outpatient codes minus the discharge summary codes again. The next slide lists now the QDC numerator codes using CMS's G code.

This is an important distinction here. So for these codes, we have to say there is EF greater than 40% or less than 40%. If the subjective language is used, it's mildly depressed or moderately to severe.

And you can see that G8470 is an EF of greater than 40% or you have an EF that's less than 40% and you either prescribe ACE and ARB or it was not prescribed for reasons not - for reasons documented in the chart.

The next slide, measure 118, option 2, requires the CAD code and the diabetes code. And those codes are listed from the family of codes that we've already talked about, including the diabetes now.

The next slide, again, lists the CPT denominator code that will be captured, so it's the new patient, subsequent care, and outpatient consults. And the QDC codes here for option 2 are G8473 ACE or ARB therapy prescribed or it was not prescribed for reasons documented in the medical record.

Turning to the next slide, which is heart failure, measures 5 and 8, the denominator codes obviously are three major categories -- hypertensive heart disease, probably not frequently used because frequently hypertensive heart disease has a normal EF. Hypertensive heart disease and renal disease, probably not commonly used by cardiology.

And the family of codes that are probably most likely to be used by cardiology are the 428 family of heart failure codes, which talk about acute and chronic systolic heart failure.

The next slide is measure 5, heart failure with LV systolic dysfunction on ACE or ARBs, the denominator codes as listed there for CPT, including on this one the hospital discharge.

The next slide gives the QDC numerator codes, the 3022F, which means it's greater than 40% or if it's 21, it's less than 40%. If you use the 3021F, you then on the next slide have to go on and report whether or not you prescribed ACE or ARBs.

So it's the 4009F that it was prescribed or not prescribed because of the exception or exclusion process that we've talked about, 1P for physician, 2P for patients, 3P for system, as listed on this slide.

The next slide is measure 8, which is heart failure with LV systolic dysfunction on beta-blocker therapy. The CPT denominator codes are similar -- the same actually.

Measure 8, the next slide, heart failure with LV systolic dysfunction on beta-blockers, we're going back to the G codes for the QDC numerator codes. G8395 is you have greater than 40%.

That's a different G code than I told you about a few minutes ago, so you must make sure you always have your G codes and your CPT codes numbered correctly.

If it's less than 40%, it's G8450, shows that they have EF of less than 40% or a moderately to severely depressed and they are on beta-blocker therapy or the 51 G code, which is they are not on and appropriately documented in the chart.

So on the next - my last two slides are kind of a summary recommendation from a - from our group that's been involved in this since 2007 and my own - myself having participated in a number of practice - presentations with CMS.

Here we go. So in order to be successful, establish a PQRI team. You need cheerleaders and champions. And this must include depending on your practice size and makeup physicians, nurses, coders, billers, and administrators.

Do a careful analysis of the PQRI specs, the performance measures, and the QDC codes, either the CPT II by AMA or the G codes by CMS. Know the criteria for the denominators, the numerators, and the exclusions, and, of course, know your NPI.

Managing the diagnosis, which is the denominator, drives the treatment performance measure, which is the numerator with the appropriate exclusions always documented in the chart. Remember that only four ICD-9 diagnoses can be submitted.

On the last slide, I can't (unintelligible) data capture, I can't overemphasize how important the data capture is. If you think about the measures that we talked about today, it's to a large extent bread and butter for cardiologists.

I would suspect that most cardiologists have in excess of 95% of the time the patients on the appropriate measure, aspirin for coronary disease, ACE inhibitors in LV systolic dysfunction, beta-blockers in heart failure with post-MIs. These are very, very commonly-prescribed therapies. We obviously pay careful attention to the lipid profile.

So chances are it's the care that you've been giving, but now it's time to report it. And in order to report it, you have to figure out how to capture it. So it's truly all about data capture and the workflow changes that are necessary to be able to report on PQRI.

Physician involvement is mandatory. Payback is obvious. There's an economic return. And, of course, the most important thing is we get better patient care and better documentation.

The web site's been referred to. It's also on this series of slides. Bookmark it. Read it frequently, particularly the implementation guide.

And I'd like to make just a couple of final comments here in the last minute or two by sort of kudos to CMS and all of the effort that they have put forth in trying to make this project work.

Obviously over the last five to ten years, there's been a tremendous emphasis on pay-for-performance, but we've got to be able to start with what represents quality, how do we measure the quality, can we report the quality, can we collate the quality, can we give feedback, can we actually make a difference in the outcomes to our patients.

So all of these are very, very important issues and CMS has really taken a leadership role in trying to make this project work. It's been a pleasure working with the people since 2007, people like Susan Nedza, and I had a chance to do a conference with Dr. Michael Rapp last week.

You know, CMS has really put an incredible effort to make this project work. If you spend any amount of time on their education - on their web site, you will see almost every possible question that you could think of is more than adequately addressed.

So with that as a final comment, I'll pass it on - I'll pass the speakerphone back to Brian to introduce the next speaker.

Thank you.

Brian Whitman: Well, I guess our next speaker is Dr. Frank Mikell from the Prairie Cardiovascular Consultants. And he'll tell us a little bit about how his practice was able to work with PQRI 2007 and now 2008.

Frank Mikell: Thank you, Brian. I hope everyone can hear me okay. I'd like to thank Brian and also CMS for setting up this opportunity to review.

We were asked to participate primarily to sort of give a bit of a practical side to the PQRI in terms of the implementation. We'll talk a little bit about - I've asked (Ed Brooks), our CFO, to talk a little bit about the structure that we put in place to deal with this.

Before we talk, though, I'd like to just make a few comments, some of which to reiterate what John does. He's done an excellent job in laying things out on the details of the program.

But I'd like to emphasize that we addressed this as an initiative that took total commitment as John sort of indicated. We need a team, but it has to be a team that is driven from the top level down.

We approached this at Prairie as a - quite frankly the benefits not being so much financial as the fact that we would be participating in a quality program, that we would learn processes and develop processes to help us in reporting for potential future programs and that we felt that there were numerous indirect benefits that we would garner from participating. And like John and his practice, we started in in the initial phases in 2007.

As we looked at this initially and sat down and got our team together and began deciding how best to approach this problem, because we

have an electronic medical record like John does, we tried to look for some very slick electronic way to do this.

And to be perfectly honest, we weren't very successful. And part of that was perhaps the time piece, but part of it was the fact that we simply did not feel that we could get the coordination that we needed to ensure that we were doing a good job.

And so after some discussion and some trial and effort, we actually went to a more what I would call old-fashioned method that allowed us to have ongoing audit and ongoing analysis of how we were doing in the process internally.

And we looked at both a front-end piece in terms of the physician participation and nurse participation in the clinic setting, as well as the obvious need for the back-end piece in the billing and coding offices as well.

One thing that has come up in some discussions about this as we've talked to other practices about our approach to this is deciding on the parameters and particularly the number of parameters.

And we've heard two basic philosophies. One philosophy was we want to have a number of these in place so that we try to make sure that we got coverage.

Our approach initially was to try to use the three parameters and to really emphasize the process to make sure that we got the results we wanted, which was total compliance with the parameters.

So we took an approach of using the currently three-parameter approach and making sure we - that we intensified our efforts in getting the job done on those.

As - I'm going to ask (Ed Brooks), again, I think this is a testimony to the level of commitment that we had in our organization. (Ed)'s the CFO of our group.

And (Barbie White), who is the Director of Medicare Accounts and Coding, will be here for the question and answer period as well. But I'd like to ask (Ed) if he could to take just a few minutes to review our basic approach.

(Ed Brooks): Thank you, Dr. Mikell.

As Dr. Mikell said, we've kind of looked at the - our major focus was on the quality of reporting. And we have (unintelligible) web pages and we thought this would be (unintelligible) right into our practice.

We did (unintelligible) back in early March, put a core group together, and said okay, we need to start figuring out how this is going to work. And, of course, it was across the board between our president and the chief financial officer, myself, as well as well as the CIO and other IS staff and our EMR staff, as well as the billing and coding director. So we tried to break down what it would take to implement this program.

Of course, initially we had the physician (executive) committee look at the measures and they selected what we considered the three core measures that we were going to report.

Once we did that, we were - we rolled out an implementation and training with - all the way down from our physicians to our nurse practitioners to secretaries to billing staff, anybody that might be touching the program.

Our next step was to actually meet with the coding department. And we kind of looked at the back end and said okay, we'll do this all in the front end, but what's it going to take to implement it on the back end.

So we met with all of our coders. We asked them what they thought it would take to get this report into the system. And we kind of got a lot of feedback on the back side.

From there, we met with our IS department. And as Dr. Mikell said, we really thought with our sophisticated EMR system that we'd be able to just drop this right in and it'd work perfect.

And the more we dug through the system, we found out maybe it's better to step back and re-look at it. And we felt the EMR itself as an automated feature wouldn't work.

And so what we decided to do is go back as Dr. Mikell said the old-fashioned way. And we pulled our charge tickets and our clinic schedules, our original documentation where we started, and said what do we need to do to capture the information?

And you'll see actually on Slide 32, it's kind of a cut-and-paste of a section of our clinic schedule. On Slide 32 on that bottom right corner, you'll see the PQRI information.

And the way we approached this is this would either be in our - if a physician used a clinic schedule to do his billing. Or if you go to Slide 34 -- actually 33 is the top half of the same charge ticket, the bottom half on Page 34 -- you'll see on the left-hand upper corner, you'll see, again PQRI information.

And this is where the physician would fill out the information necessary to complete the measurements that we selected.

Back on May 6 of 2007 after defining the goals, we decided we'd start rolling it out. And we had many meetings with both physicians at their group meetings with our (NPMPA) meetings, the secretaries meetings, the coding meetings, we were making sure that before the start everybody understood what they needed to do.

One of the things we required is that every bill had to have it completed, this section with the PQRI. So what we did is we weren't requiring the physician to determine if this a PQRI patient or not.

We said 100%, it doesn't matter if it's Medicare or non-Medicare, you're going to complete the PQRI information. And by completing it on 100% of the bills, it took it off the decision-making on the physician side and pushed it back on the coding side.

Initially if the doctor didn't complete that section, we would return the billing to him. And it was a 100% participation, both by doctors and by the nurse practitioners and physician assistants. So there wasn't any choice, I do or don't want to do it. It was 100%.

We also required the people that at the time they did the charge ticket, some practices we talked to said well, they filled it out and later on

we'd pull the charge up and we looked it up. We required (to fill out) at the time of service, so there wasn't any back-end additional work that they had to do.

On the coding side, what we did is we put together laminated information for the coders with - in the area of the PQRI and the diagnoses in there. So we had the back side with documentation.

One of the things we ran into, of course, is that with the coding side is that if we have Medicare secondary is if any of you dealt with the Medicare secondary side, when you're in the clinic, sometimes it's not always - it's easy to know what the primary insurance is, but sometimes the secondary is not always up front in there.

So what we had to do on our EMR system is that when the billings were done, a lot of times if it's Medicare secondary, it went in under a commercial insurance. But since there's zero charges in there, they got dropped.

So when Medicare as secondary was filed, it was a manual process by our coding department to make sure that each one - each of the bills were completed for the PQRI. They had to basically go back in and redo those codes.

We also when the coders entered the information, before the process was done for billing, they actually printed out what we call a PQRI audit trail. So if the coder enters the information and they didn't pick up a PQRI measurement and it should've been, our computer system would match up the definitions that were done by our programmers and tell us that we're missing one of the measurements. The coders

would then go back in before the bill was processed, re-look at the information and put it in the system.

So what we had is a requirement that every bill had to be checked and approved before it went out. What this allowed us to do is if the physician did 100% on the front end and the coders basically we made sure it was 100% entered on the back end in there.

So with that approach, we able - we were able to have a 100% satisfaction and reporting for 46 physicians in our 16 (NPMPA)s for 2007.

Frank Mikell: I'd like to just follow up before we turn it over to Sylvia and just reiterate that even though this required obviously a process change, one of the things that we found is that by eliminating the decision of do you do it on this patient versus that patient and just going to every patient, we felt that that was the most reliable workflow pattern for the physician on the front end.

So - and basically what we found is that the workflow became rapidly established. People looked at this as just more thing. It takes them only a few minutes.

Our - it also enabled our documentation process to be more thorough and not just apply to Medicare patients. We have a web-based tool that we use to make sure that we try to define compliance with all ACC guidelines.

And as part of that, if there's a contraindication say for a beta-blocker or an ACE or aspirin, we document that in our web page and it becomes a permanent documentation in our electronic medical record.

So we actually found that that improved that piece of documentation as well.

So we'll stop there and turn it over to Sylvia at this point.

Sylvia Publ: Good afternoon, everyone.

I'm thankful for the opportunity to address you this afternoon. We're going to start with Slide 3, give you an overview of my presentation. We're going to discuss the context in which PQRI was created. And that is a value-based purchasing initiative that CMS - or direction that CMS is going toward.

We are going to talk about PQRI reporting. You've heard a lot about measures and codes. I'm going to give you a little bit more about that, what to do about implementing, and I commend Frank Mikell and his staff for the excellent way, strategic way that they took in implementing PQRI.

We have found in looking at across a number of practices throughout the country, those that took this kind of careful, strategic approach tended to be more successful than those who said well, I'm just going to report a code on a claim and I'm not going to worry about it.

And we'll talk about some of the reasons for failure. And then lastly, you will have slides that will give you some resources about PQRI for those of you who are new.

Going on to Slide 4, just want to talk about value-based purchasing. Value-based purchasing is CMS's term for pay-for-performance. We are not in pay-for-performance now. PQRI is really a precursor to that.

We are in pay-for-reporting because we need to be able to walk before we can run.

And value-based purchasing frankly reflects national policy concerns about the unsustainable cost increases that we're seeing in healthcare and the uneven quality of care, also the high rates of medical errors. We've seen expenditures in Medicare go from $219 billion in 2000 to a projected $486 billion plus in 2009.

The Part A trust fund, we are seeing excess expenditures over tax incomes in 2007 and we projected that to be depleted by 2019 if the trend continues.

Part B trust fund, expenditures are increasing at over 11% per year over the last six years.

Medicare premiums and deductibles, cost sharing are all projected to consume 28% of the average beneficiary's Social Security check in 2010.

Historically Medicare reimburses for services as long as claims are submitted appropriately and according to administrative and policy regulation. And this is regardless of the quality of the services rendered and regardless of whether the services were appropriate to that patient or whether they led to improved outcomes.

Fee-for-service, prospective payment based on resource consumption and not on outcomes, provides neither the incentives nor the support to improve the quality of care for our beneficiaries.

As many of you know, Medicare is the largest purchaser of healthcare in the world. We spend - we have 44 million beneficiaries. And, of course, that is expected to grow as the population ages.

In addition to the expected growth, we have concerns about the sustainability of financing for this program. The past 30 years, Medicare spending has risen an average of 9.3% annually, considerably higher than the gross domestic product, which is at about 6.5%.

Currently CMS spends $1 billion per day in Medicare. And as you all may be aware, the Institute of Medicine has published a number of studies about the quality of care. The - one particular, the Crossing the Quality Chasm, was published in 2001.

And that was the first study that the Institute published. And a number have followed since, which highlight the significant gap in what we know is good care and what actually gets delivered.

We know that beneficiaries do not always receive the care they need. We've seen from Beth McGlynn's work published in the New England Journal of Medicine, there are tremendous opportunities to improve the quality of care.

And from Weinberg's work on variation, that there are significant geographic disparities in the amount of services beneficiaries receive and that we pay for that may not necessarily lead to improved outcomes and could possibly expose beneficiaries to higher risk for additional cost.

So policymakers are asking: Are taxpayers getting good value for the dollars we're spending? And on Slide 4, you'll see how PQRI began with 74 measures.

TRHCA, the Tax Relief and Health Care Act of 2006, established PQRI and established the incentive that was to be paid for reporting of measures for a half-year program, 2007. And in 2007, PQRI was a claims-based-only program.

Medicare then passed additional legislation with (MMSE) in 2007 for 2008 and the program grew from 74 measures to 119 measures. And we see now that in 2008, there were two ways of reporting, claims-based reporting of measures, individual measures, claims-based reporting of a choice of among four measures groups, or registry-based reporting of individual measures or measures groups.

(MIPPA) in 2009 expanded the program to 153 measures and now we see that we've got individual measures that can be reported through claims. We expanded the measures groups to seven.

We are obviously going to continue with registry-based reporting and we have seen quite an interest in the number of registries that have self-nominated for reporting for 2009. And we will be testing electronic health record-based reporting.

And finally, we have a separate incentive program, the e-prescribing incentive program. The incentive for 2009 are 2% of total allowed charges for PQRI, plus you can also qualify through the e-prescribing incentive program for an additional 2% for a total of 4%.

And then in 2010, we are in the process now of rule-making for 2010. The ARRA has provided us with additional regulatory changes that we will need to make to the program going forward, but we can anticipate that registry - expanded use of registries or - and testing EHRs will definitely be in that program. As you all know there's an awful lot of interest in the incentives involved in establishing electronic health records in physicians' offices through the ARRA incentives that were legislated.

Going on to Slide 5, this is a description of how the claims-based process looks like. Basically CMS used the claims-based process to jumpstart PQRI because it was the only national data collection infrastructure that we had that everyone could avail themselves of.

And just walking through this slide starting from the upper left-hand corner, we have (a visit) documented in the medical record that documented - that visit will then be documented in an encounter form or some other data collection form that the practice decides to use, which is used to communicate with coding and billing staff.

The staff submits a claim to the carrier MAC. The MAC will then submit a remittance advice or some of you know it as the EOB, but it's basically a remittance advice that the practice gets.

And for every quality data code you submit for the measures selected, you will receive remark code N365 that says this code is not payable, it's for information-purposes only.

The N365 message does not tell you whether you did this right or wrong. It basically just says we received a quality data code with a zero charge and we are telling you that there is a zero charge attached

to it. But it also tells you that the carrier's processing system did take that PQRI code and passed it on to the National Claims History file.

From that National Claims History file, the analysis contractor is required to take all claims that have an NPI in the rendering provider ID field and analyze them for PQRI.

The analysis contractor then submits a confidential report to CMS about the experience with the coding and the measures and subsequently - and recommends or tells us which eligible professionals made the incentive.

That file then - payment file is then submitted back to the carrier, who will then issue the incentive payment to the eligible professional.

I do want to say a couple things about the confidential report, emphasis on confidential. From the physician standpoint, they may not think that a feedback report would be confidential since it contains a bunch of numbers.

But, in fact, your tax ID number and your NPI number are confidential pieces of information and certainly your quality information would be considered confidential. And so there is a process to access the confidential report through a secure web site, QualityNet.

In order to access QualityNet, you do need a password because we can't just give it out to anybody. That password and user ID is provided to you when you register through IACS.

Going on to Slide 6, some resources that you can use to begin when you're assessing whether to start or continue with PQRI, you need to avail yourselves of the current program year's information.

We have found in the past that some professionals used 2007 in 2008 specifications. And so if you're using outdated specifications, you will not be successful in this program.

For 2009, we have a PQRI measures list. It identifies the measure developer and the type of reporting method that's available for that particular measure. We have, again, the 2009 PQRI measure specifications manual for claims and registry. These are for individual measures reporting via claims or registry. We have a 2009 PQRI implementation guide that Dr. Schaeffer kindly mentioned before.

That implementation guide walks you through how you can begin to report quality data codes. It includes a sample claim in 1500 format that has call-outs that show you what information goes where and why.

Again, you may be interested in reporting a measures group. There are seven. I don't believe - cardiology does not have a measures group for 2009, but I understand that there has been a request made to create a measures group for cardiology for 2010.

But if you are interested in measures groups, there's a separate specifications manual for measures groups because a measures group is basically a group of clinically-related measures.

And the denominators to create the measure group will be different from the individual measures. We needed to do that so that we're all

talking about the same kind of patients and that all of these processes belong to this one patient population.

New for 2009 with measures group reporting there is a composite G code that can be used that says of seven diabetes measures, for example, I have completed all seven. And so rather than reporting each individual measure on a claim, you would simply report the one composite G code.

Again, there's a resource such as the Getting Started guide. That getting started document is the implementation guide for reporting of measures groups, which is different, again, from the reporting of individual measures.

Onto the next slide, number 7, some more resources, there is registry-based reporting. You can find that in the reporting section of the PQRI web site. Registry-based reporting is available for the reporting of at least three individual measures or a measures group.

And, of course, on that section of the web site, you will find a list of qualified registries, which will be updated later in the year after we go through the process of qualifying the registries for 2009.

Registry-based reporting is the most flexible way of reporting to PQRI. The registries give you all of the information that you need to have. There is a fee associated, of course, with registry-based reporting.

Additional educational resources are also available on the PQRI web site. You'll find MLN Matters articles, fact sheets, tip sheets, a patient-

level measures list, which is a list - a subset of the PQRI measures list that requires one-time reporting per patient per individual NPI.

Slide 8 -- for claims-based reporting, we have a number of principles. These are delineated in the 2009 implementation guide. I won't go through all of them.

But for claims-based reporting, suffice it to say at this point you need to understand that the claim must contain the quality data code for the beneficiary, same date of service, same individual eligible professional by their individual NPI.

And that claim - for us, the claim means that you're reporting both the numerator data and denominator data. What I mean by that is that the denominator codes on that claim is consistent with the measure denominator.

You have a diagnosis on that claim and you have an office visit code, for example, on that claim. That combination with the numerator code that is also on the claim does tell CMS that you are reporting on a specific measure.

When any of those components -- denominator or numerator -- are missing from the claim, we have a problem.

Obviously not all claims will be eligible for specific measures. As you saw with Dr. Schaeffer and Dr. Mikell's presentations, there are certain CPT Category I services for which we would expect to receive a quality data code and for others that we would not.

For cardiology, many cardiology practices have decided that when they do select their measures, they will report them 100% of the time regardless of the patient, which is fine.

Just know that sometimes we will consider invalid reporting when you submit a quality data code on a claim, for example, and the CPT Category I (service) does not match the denominator coding for the particular measure that you are intending to report.

When there's a denominator mismatch like that, it may not - it will not count against you. It’s just an instance of invalid reporting that we set aside.

You may be counting it in your numbers by mistake because that's something that you reported, but, in fact, it is a denominator mismatch and it will not necessarily count against you.

I won't go through slides 8 and 9. We're going to skip to Slide 10. But I do want to point out you should be familiar with claims-based reporting principles.

One thing that you can not do is you can not resubmit, for example, a claim simply to add or correct a quality data code. That quality data code has to be submitted at the time of billing for the CPT I service that you are billing.

Going on to Slide 10, we have a 1500 claim example. This is taken from the implementation guide. And this one is describing a patient who is seen for an office visit, 99213. The provider is attempting to report several measures in this claim sample related to diabetes, coronary artery disease, and urinary incontinence.

I'll draw your attention to the diagnosis section of that claim, where you won't see the diagnosis of urinary incontinence. Why? Because the measure that was selected does not require a diagnosis, in which case it doesn't need to appear on the claim.

And by the way, another issue that we found with some of the claims that we saw is that some billing systems will limit the number of diagnoses. CMS for electronic billing does not limit the number of diagnoses. You almost have unlimited number and also an unlimited number of lines on your claim.

But billing software and clearinghouses do have limitations and it is important for you to understand those limitations.

Again, on this claim, you will see for measure number 2 the quality data code 3048F appears. And that quality data code with the diagnosis of diabetes tells us that they are reporting on measure number 2.

The second line we see that they are reporting quality data code 3074F and 3078F, which corresponds to measure number 3, blood pressure and diabetes. They are reporting both systolic and diastolic blood pressure.

Going on to the third code being reported, 4011F with a diagnosis of coronary artery disease, again, that tells us that you're reporting measure number 6.

And finally, quality data code 1090F is not associated with a diagnosis, but 1090F is unique to measure number 48, so that tells us that code for that particular measure is being reported.

You will see on this claim a field called the diagnosis pointer -- the pointer points that is- it relates that particular line item to a diagnosis on the claim. When you don't have a diagnosis associated with a particular measure, that pointer field can default to number 1, which would be your primary diagnosis.

We have found in 2007 experience that some billing software routinely always placed the number 1 in that field. And if you are attempting to report a diagnosis and that was a secondary diagnosis and the quality data line item pointed to the primary diagnosis, we would end up with a denominator mismatch.

And the reason that occurred is that PQRI analysis was focusing only on the diagnosis pointer field in 2007. We are analytically changing that process so that all diagnoses on the claim will be considered and not just limited to whatever was on the diagnosis pointer. That's one of the reasons for re-running 2007 PQRI data.

We also found that some other software would routinely point to all four diagnoses, so you'd find, for example, in that field 1, 2, 3, and 4. Only one diagnosis pointer number will pass to the National Claims History file. That is the first listed one. So, again, that caused some diagnosis problems for 2007.

Again, you'll see on this claim form that the NPI, is the individual NPI that needs to be placed on the line item that contains the quality data code that you're reporting or the CPT I service that you're reporting.

Going on to Slide 11, how do you get started? We've heard from both Dr. Schaeffer and Dr. Mikell, it's important to gather information.

Know the information. I have been talking to a number of practices who have never gone on to the PQRI web site.

If you're not using the primary sources, you'll get into trouble. Please use the primary sources from the PQRI web site. Know the codes. Be sure that you have the right codes. Everything you need to get started is up on that web site.

You can also gather information from other sources such as ACC. The AMA also has data collection worksheets for each of the PQRI measures.

Determine what PQRI reporting options best fit your practice. Will you be reporting individual measures, will you be reporting a measures group, do you want to use a registry for reporting or will it be claims-based reporting?

Also determine what PQRI reporting period that you have. For 2009 PQRI, claims-based reporting, we have a one year option only. And that started January 1 and goes to December 31 of this year. If you're going to report through a registry, you have a little more flexibility.

Going on to Slide 12, consider your practice characteristics. Consider which measures you would like to report and which ones best meet the practice's quality improvement goals.

Again, review the measure specifications that are posted on the PQRI web site because that is what will tell you how to report.

Slide 13 -- selecting a reporting method via claims or qualified registries, there is a decision tree. It's on the - it's an appendix to the

implementation guide. That decision tree will walk you through how to make a decision on which method would best fit your practice.

Slide 14 -- again, we've heard from both Drs. Schaeffer and Mikell, it is important, assemble that implementation team, know how your claims are processed, know what your vendors are doing, your billing software, your clearinghouse. Ensure that they all have the codes and are up to speed with the reporting of the measures that you have selected to report.

Again, imperative to discuss this with your staff -- everyone needs to be onboard if you want to report these measures and that this is meaningful to you and to the practice.

Slide 15 -- develop a process for concurrent data collection. This is very different for practices to do. They've never done this before. Concurrent data collection is important because the - generally the opportunity for quality arises during that encounter with the clinician. It - quality doesn't mean anything if you report it after the fact. The opportunity is there during that encounter.

Again, many practices never looked at their remittance advices. Do regularly review the remittance advice, make sure that you're receiving the N365 from your carrier or A/B MAC. And if not, call them and find out what the problem is.

Slide 16 -- let's talk a little bit about the 2007 Experience Report. We have published this report on the web site. You have the URL here on the slide.

We thought in 2007 that there were a lot of physicians that did attempt to report, but their NPI was missing from the claim. Some physicians did not have an NPI and decided to participate in PQRI and to obtain their NPI at the same time.

Those two would not coincide very well together for the short period of time that we had of six months in 2007.

We now have a hard edit on the claim for the NPI so that if your NPI is not on the claim correctly, that claim will reject. That was not possible to do for 2007. So the NPI was a basic business requirement.

Again, we found that almost 20% of claims that were coming in were coming in with the wrong CPT I service code on them. Again, this is what we term a denominator mismatch. Another mismatch would be that if there was an incorrect diagnosis code on the claim.

Well, we've seen issues with the diagnosis pointer that could have resulted in a diagnosis mismatch. We've also seen split claims come in where the clearinghouse or the billing software actually split the claim and the provider might not necessarily have known that the claim was split.

Again, this is a fix, an analytic fix that we are undertaking for the 2007 rerun of data. We can rejoin the claims that were split based on the same beneficiary, same date of service, same NPI, same tax ID number.

And lastly, we found claims that were being submitted that only had quality data codes on them. If there is a claim submitted because somebody forgot, for example, yesterday we billed a number of codes

and we forgot to put quality data codes on some of them. And some folks were trying to submit bills after the fact. You can not do that. We will not consider claims that have only quality data codes on them.

Going on to Slide 18, we have a table here that tells us what we're seeing in 2008 for reporting. This is an aggregate error report that has been posted on the PQRI web site and you have the URL on the slide.

We're seeing, for example, that measure number 5, heart failure, only 53% are being validly reported. We're seeing incorrect diagnoses on claims.

For measure number 6, we're seeing an - both a combination of incorrect diagnoses and incorrect HCPCS or CPT I service codes; same thing for number 7 and number 8, incorrect diagnoses.

What this tells me here is that similar to 2007, 2008 also had that diagnosis pointer field affecting, as well as split claims affecting the claims that we were seeing.

We are applying these analytic fixes to 2008 going forward, so these numbers are going to change. In April, we will be posting a new aggregate error report for 2008 that will contain more valid information or useful information.

But I would impress upon you if you're concerned at all about how your measures are being reported, take a look at that aggregate error report that we will post in April because it is a table of measures that will tell you what we're seeing and what the trends are.

I would anticipate that for cardiology, which was largely affected by a diagnosis pointer issue, that these numbers would improve quite a bit going forward.

Slide 19, some common errors that we've seen, again, the NPI not being listed on the claim. In some cases in '07, the clearinghouses stripped the NPI or used the legacy number to pay the claim and not the NPI.

We have seen missing -- and this is a big one -- missing the quality data code on an eligible claim. A number of practices have come to me asking why they didn't make the incentive and what the reason was. And when we looked, we did find that they missed a number of cases that were reportable. And that's because the front office function may not have been in tune to identify all of the cases and they were depending only on the front office to identify eligible cases.

Reporting of quality data code on a claim for a diagnosis that wasn't listed in the denominator for the measure -- and this one pretty much tells me that the practice did not really understand the measure or the measure specifications that they were attempting to report; reporting a quality data code on a claim with an office visit code when the measure calls for a surgical procedure code or a consult code, reporting a quality data code on a claim when the diagnosis and the CPT I service were not listed in the denominator for the measure at all -- in other words, we've got a quality data code being reported, but that claim is not eligible at all; reporting one quality data code when the claim requires two quality data codes; or reporting one diagnosis on a claim when two are required, such as measure number 5 -- excuse me, measure number 7, as Dr. Schaeffer alluded to before; reporting of a quality data code with a CPT I modifier. We had been lenient in '07

and in '08 about the modifiers, but we do anticipate that by now most folks to should understand that CPT I modifiers belong with CPT I codes. CPT II modifiers, 1P, 2P, 3P, or 8P, belong with quality data codes.

Excuse me.

Reporting a quality data code on a claim for a service that was not covered by Medicare as these are denied claims and we have found that some folks when a claim was denied, they didn't come back and resubmit a claim with that quality data code on there.

Going on to Slide 20...

Natalie Highsmith: Excuse me, Sylvia, I'm sorry to interrupt you, but in the interest of time, we need to move on to the open Q&A for the remaining minutes of the call. Did you have any closing remarks (unintelligible).

Sylvia Publ: Yes, I think pretty much covered most of the types of errors that we've seen. The rest of the slides are here for your benefit. You can avail yourselves of the information on those.

So I thank you very much and we can open it up to questions and answers.

Natalie Highsmith: Okay, (Laurie), if you could remind everyone on how to get into the queue to ask their question. And everyone, please remember when it is your turn to restate your name, what state you are calling from, and what provider or organization you are representing today.

Operator: Thank you very much.

I would like to remind our participants if you have a question, please signal us at this time by pressing star-1 on your telephone keypad. Once again, that's star-1 to ask a question.

We'll take our first question today from (Janet Muse) is Missouri.

(Janet Meives): This is (Janet Meives) from Missouri Cardiovascular Specialists.

When you were talking about the modifiers, what should we do when we have a locum tenens and we have to put the modifier on the HCPCS code that even though we're - this doctor is the doctor that we're billing, it was a locum tenens filling in for him. How will that affect the PQRI and billing that?

Sylvia Publ: What NPI are you putting on that claim?

(Janet Meives): We are - you - we put on the doctor they are replacing because when you bill locum tenens, you still bill it under the doctor that they are replacing.

Sylvia Publ: Right.

(Janet Meives): The doctor who is...

Sylvia Publ: And that is the physician who would get credit for that quality data code.

(Janet Meives): Right.

And do we need to put any kind of modifier on the quality data code or...

Sylvia Publ: No, not at all.

(Janet Meives): (Unintelligible) okay. Thank you, because we had been so we'll stop doing that. Thank you.

Sylvia Publ: That's a good idea. What modifier were you using?

(Janet Meives): I think it's the Q6.

Sylvia Publ: Yeah, Q6 is not a modifier to be used with quality data codes.

(Janet Meives): Okay.

Sylvia Publ: The only ones that we allow for a quality data code is the one 1P, 2P, 3P or the 8P.

(Janet Meives): Okay. I'll have my staff change that then and no longer do that.

Sylvia Publ: You're welcome. By the way, there's also an FAQ out there. If you use the keyword locum or locum tenens...

(Janet Meives): Okay.

Sylvia Publ: ...in an FAQ.

(Janet Meives): Great. Thank you so much.

Sylvia Publ: You're welcome.

Operator: Our next question will come from (Mitzy Duncley) in Georgia.

(Mitzi Dunkley): Hi. My name is (Mitzi Dunkley). I'm calling from Lawrenceville, Georgia, the Cardiovascular Group.

My question is pretty simple. I missed out on when you identified the PowerPoint presentation that you were referring to. Can you give me that link or was that available to everyone?

((Crosstalk))

Sylvia Publ: Yes, the PowerPoint presentation that I just - that we all just finished giving...

(Mitzi Dunkley): Yes.

Sylvia Publ: ...it's available on the ACC web site if you go to the home page. It will also be posted on the CMS web site subsequently to this.

(Mitzi Dunkley): On March 26?

Sylvia Publ: Yes.

(Mitzi Dunkley): Okay. Thank you.

Sylvia Publ: You're welcome.

Operator: We'll take our next...

Natalie Highsmith: There is a - I'm sorry, (Laurie). There is a web link to the slides on the Physicians Open Door Forum web page right now under the related links outside CMS. That's also where the link is housed.

Operator: Thank you, Natalie.

We'll go to our next questioner, (Jeanne Thompson) in Massachusetts.

(Jeanne Thompson): Hi.

We were actually wondering if the rerunning of the 2007 data would result in any additional payments.

Sylvia Publ: If you qualified for an incentive, it did - those cases are not going to be rerun at all. It's only those who did not qualify.

(Jeanne Thompson): Right. We were - we had a problem with the diagnosis linking, so.

Sylvia Publ: If you had a - if you've identified that kind of problem...

(Jeanne Thompson): Mm-hm, yep.

Sylvia Publ: ...yes, that's the reason we're doing the 2007 data. And that information, the reports for 2007 rerun will be available in the late fall of 2009.

(Jeanne Thompson): Okay, thank you.

Sylvia Publ: You're welcome.

Operator: Our next question comes from (Rose Heald) in Wisconsin.

(Rose Heald): Yes, thanks for taking my call. I'm calling from the Medical College of Wisconsin.

And I have a question about the registry-based submission. Am I correct in interpreting -- it's on Slide number 8 -- that the American College of Cardiology is going to become or is attempting to become a registry? And if so, for what measures would that registry be capable of transmitting?

Sylvia Publ: Well, I can tell you that the college has submitted a letter of nomination. And that's as far as we can take it right now because we will be going through the testing and ensuring that they can actually submit the data on behalf of their constituents. They did quality in 2007 as well as a registry.

(Rose Heald): Okay.

Can you tell me what measures can be submitted for - through that registry?

Sylvia Publ: All of the cardiology measures.

(Rose Heald): All cardiology measures, okay.

(Laura Slattery): I'm not sure that that's the case. This is (Laura Slattery). I'm Director of Quality Services at the American College of Cardiology.

The ACC, as you're aware, has a number of different registries. We submitted for PQRI 2008 reporting to be recognized using the IC3 program. And we have successfully completed all milestones for that,

including submitting on behalf of physician practices for the 2008 reporting period.

We are submitting to be - to - our letter of intent to continue for participation in 2009 PQRI. And we make all information regarding participation through the IC3 program available on the web site, which is www.ncdr.com, which includes the measures that you will be able to report through the IC3 program.

(Rose Heald): Okay.

(Laura Slattery): The IC3 program because it includes participation by internal medicine and family practice physicians goes beyond cardiovascular measures for reporting. And we're in the process of reassessing the 2009 individual measures and we'll be posting that information as it becomes available.

(Rose Heald): (Unintelligible).

(Laura Slattery): The other thing that I just want to clarify is that there is no charge through the college to participate in the IC3 program or to have us submit on your behalf if we're selected by CMS for 2009 PQRI for us to be able to report on your behalf.

Obviously there's decisions that have to be made at the practice level, where you may incur costs for coding, for collecting and submitting the clinical data to the registry program.

(Rose Heald): Could you give the web site again, please, where I could get more information about that registry reporting?

(Laura Slattery): Sure. If you go to the www.ncdr.com web site and then you click on the IC3 program link, you will find information about the PQRI reporting options.

(Rose Heald): Okay, thanks very much.

(Laura Slattery): Mm-hm.

Operator: We'll take our next question from (F. Batel) in Pennsylvania.

(F. Batel): Hi, good evening. On behalf of Dr. (Kansupada), I would like to ask a question in reference to is it appropriate for cardiologists to submit any group measures from the seven groups?

Sylvia Publ: If those measures groups apply to your practice, yes, you can. But you are required to submit the entire measure group.

(F. Batel): Right, okay.

And the second question is is there a way to find out if you passed through because every claim that comes back on the (EOB) on the codes does have an N365, but we don't know whether we made it.

Sylvia Publ: If your remittance advice is telling you that you have N365 now and you...

(F. Batel): Mm-hm.

Sylvia Publ: ...and you are putting the individual NPI on your claim, you should have no reason to doubt the accuracy unless you're completely coding something different or you're using the wrong specifications.

(F. Batel): Okay, thank you.

Sylvia Publ: You're welcome.

Operator: Our next question comes from (Neela Zafar) in Utah.

(Neela Zafar): Hi.

I have a question regarding the confidential reports that are available on QNet. Do they have - are they physician-specific or do they have any benchmark data? And if so, what do you use as the benchmark?

Sylvia Publ: The feedback reports do have information like that. And we do have a user guide that will explain how to look at the feedback report on QualityNet.

(Neela Zafar): Oh, okay. Thank you.

Sylvia Publ: You're welcome.

Operator: Our next question today comes from (Cathy Nelson) in Hawaii.

(Cathy Nelson): Yes, my question is do you anticipate that in 2010 PQRI...

Natalie Highsmith: I'm sorry, (Cathy), can you speak a little louder, please? We can barely hear you.

(Cathy Nelson): Okay, yes, my question is do you anticipate PQRI in 2010 will be a pay-for-performance environment? And if not, when do you anticipate that it will transition to pay-for-performance?

Sylvia Publ: Value-based purchasing or pay-for-performance will be phased in. And we will be announcing all of that phase-in through rule-making. And that's as far as I can tell you about 2010 because we are in the process of rule-making now.

(Cathy Nelson): Okay.

And when do you anticipate the rule-making will be published?

Sylvia Publ: Rule-making, we typically publish those in the late spring, in May, and then again a final rule goes out in November.

(Cathy Nelson): Okay. So for...

Sylvia Publ: (Unintelligible) opportunity to comment.

(Cathy Nelson): Okay, so there will be one for 2010 later in the - later in this particular year?

Sylvia Publ: Yes.

(Cathy Nelson): Okay, thank you.

Sylvia Publ: You're welcome.

Operator: Our next question will come from (Lea Moitoso) in Massachusetts.

(Lee), your line is open. Please go ahead with your question.

(Kim): Hi, I'm sorry. My name is actually (Kim). I'm calling from (Certa) Cardiology in Massachusetts.

We're looking into getting into this coding and just wondering time-wise and base-wise on how much time people have spent to actually get started on it and where are best resources other than this phone call to go for information.

Sylvia Publ: Dr. Mikell or Dr. Schaeffer,

Frank Mikell: Yes.

Sylvia Publ: ...did you want to answer that?

Frank Mikell: Well, I'll certainly comment.

I - as we mentioned, I think that the - this does require a fair amount of up-front commitment to understand and to design how you to approach this. The design may vary, you know, depending on your particular style of practice, how you do things, et cetera, but it does require a clear understanding in our - at least in our opinion of workflow process, both at the clinic level if you're doing it primarily as an outpatients, as well as in the billing and coding department.

So it is something that it's very difficult to do, I - without having some commitment.

And in terms of the best resources, the first thing is to get your team together and then the resources as has been commented, there are numerous resources available. Dr. Schaeffer talked about the

resources, the CMS, you know, publications, the CMS online information.

But a lot of this also is sitting down, talking to - among yourselves and to other people about how they do this. For example, Dr. Schaeffer before this got started did several presentations.

I had the opportunity to sit down with him and canoodle in Orlando at a meeting about how are you going to this. So I think there are both formal and informal ways of gaining information.

John Schaeffer: Well, and this is Dr. Schaeffer. I would agree with that. It's - as I mentioned in my slide, it's really about data capture. So you've got to figure out which measures you're going to go after, what the specifications are, how your physicians and all of the other people involved in the practice are going to (relate) to capture this data.

The ACC is prepared to help you in a number of ways. On the last slide was a toolkit for success. There's a number of options in terms of calling people - calling questions in and helping the various practices gather the data. It's all about making a time commitment to capture the data.

Chances are you're doing the work, but you've got to capture the data in such a format that you can report it on your claims so that CMS receives all of the accurate information and therefore eventually gives credit with the incentive bonus.

Frank Mikell: And the ACC tools are very valuable. And now that there is experience, there are a number of people within the ACC that can, you know, help as well.

(Kim): Okay, thank you for your answers.

Operator: We'll take our next question from (Christine Hart), also in Massachusetts.

(Christine Hart): Hello?

Operator: Ms. (Hart)? Yes, please, go ahead.

(Christine Hart): (All right). Okay, I'm not from Massachusetts, we're from Pennsylvania, (Marble) Medical Associates.

I'm wondering if it's just for straight Medicare reporting or is it for HMO Medicare?

Sylvia Publ: PQRI is a Part B Medicare program, not Part C...

(Christine Hart): Part B Medicare only.

Sylvia Publ: ... Yes

(Christine Hart): Okay.

Sylvia Publ: So Medicare Advantage patients are not included. You do not ever need to report a code on a Medicare Advantage patient.

(Christine Hart): Okay.

Sylvia Publ: You may have heard that some practices received a - an incentive check from a Medicare Advantage organization. The reason for that is

that they're required for parity purposes to pay the same as traditional Medicare in certain circumstances.

And a payment file of all incentive-eligible professionals will go to the MA organizations from CMS. And on that basis, that Medicare organization will decide whether or not it meets the plans' parameters for paying out an incentive. But...

(Christine Hart): (Okay).

Sylvia Publ: ...in order to report, you would not be reporting quality data codes on a Part C patient. And, in fact, when we look at the National Claims History file, we're only going to take Part B claims for the analysis.

(Christine Hart): Okay.

And someone else told us if you do 30 consecutive patients and you miss one who was eligible, the whole thing is lost. Is that true?

Sylvia Publ: That is true. They - you need to have a 30 consecutive patient sample for each individual physician or eligible professional, yes.

(Christine Hart): Okay. All right, thank you.

Sylvia Publ: You're welcome.

Natalie Highsmith: Okay, (Laurie), we have time for one final question.

Operator: At this time, there are no further questions.

Natalie Highsmith: Okay, great.

I will turn the call over to Dr. Schaeffer or Dr. Mikell or to Sylvia for any closing remarks.

John Schaeffer: This is Dr. Schaeffer. I - earlier I had said that this is a train that's left the station. Pay-for-performance is not going away. We need to improve the quality of care.

We need to have more efficient effective use on a cost basis. You've got to start someplace. This is an opportunity to get on early and to learn how to report.

It's the data capture that you're going to need to establish in order to be successful. So I would strongly encourage anybody who's not participating in the previous years, '07 or '08, to get onboard in '09 because you've got to do it.

Frank Mikell: This is Dr. Mikell. I'll just reemphasize but also point out that the benefits of getting onboard with this will I think be - give you a platform for future programs.

For example, on e-prescribing, we were able to adopt our e-prescribing program virtually within a matter of a day or so because of our experience with this and the platform that we created and the understanding as John said about data capture and workflow process. So it is an opportunity for - it's not just the PQRI I think. It's a useful tool.

Sylvia Publ: Thank you. This is Sylvia Publ.

I would agree with the speakers that we are - we're still in the infancy in terms of measure development. And some of you may ask well, you know, these measures aren't going to help me improve my practice. We already do all of this. And we've heard that many times from a variety of specialties.

Yes, the measures may be a bit low bar at this point. But we need for practices to begin to understand how to look at their patient population by diagnosis, by multiple filters.

And PQRI is one opportunity. PQRI may come, may go, but something else is going to take its place and it will require data capture on the behalf of the practice.

And so the sooner that you can begin to recognize your workflow so that you can capture data on specific patient populations, you'll be that far - that much more ahead as the program evolves.

Thank you very much, everyone. I do want to say that tomorrow there is a national provider call. You can still register I believe by close of business today. And that information is on the PQRI web site in the CMS-sponsored calls page.

So if you have not yet registered for the call, I would appreciate, you know, I would encourage you go do so.

Natalie Highsmith: Okay, and also there is a email address for people to send inquiries. The email is pqri_inquiry@cms.hhs.gov. That's pqri_inqury@cms.hhs.gov.

(Laurie), can you tell us how many people joined us on the phone lines?

Operator: We had 228 today.

Natalie Highsmith: 228. Wonderful. Thank you, everyone.

Operator: Thank you very much, ladies and gentlemen, for joining today's CMS conference call. This concludes your conference. You may now disconnect.

END